filled with water, and further distended to the utmost by insufflation. The instrument gave rise to no symptom beyond a little uneasiness, which lasted a couple of hours after its reintroduction. On the 2d of December, as some pain in the abdomen was complained of, the pessary was extracted, and the organs were examined. Mr. Brockendahl was much astonished to find that the inversion had disappeared, the cervix admitted of the insertion of three fingers, and its labia were well defined. The womb was measured and was found to exceed, by more than half an inch, its usual dimensions. The cold douche soon restored the viscus to its natural size, and the hemorrhage, which had lasted so long, ceased, and has not since returned.—*Glasgow Medical Journal*, July, 1861.

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67. *Puerperal Fever.*—Dr. W. T. Fox read an interesting paper on this disease before the Obstetrical Society of London, November 6, 1861.

This paper was intended as an abstract of the history of puerperal fever as it occurred at the General Lying-in Hospital from 1833 to 1858, both inclusive. It appeared from statistical evidence that 180 deaths occurred out of 5,833 labours, giving the very high death-rate of 3.085 per cent. The author then proceeded to show that from the want of a clear understanding of the nature of puerperal fever, much had been mixed up under the head of the latter which was foreign to the subject; that disease in the puerperic took on an abdominal aspect, and so offered deception; that the history of the childbed fever appeared to be a compound of acute specific diseases—local inflammatory conditions—diseases characterized by severe pain and excess of normal reaction; that after eliminating these, the major part of the cases forming true puerperal fever remained, which were explicable, according to the clinical history of the General Lying-in Hospital, by erysipelas; that in tracing the connection between erysipelas and puerperal fever, the different epidemics formed links in the chain of gradation and identity; that all the symptoms of intense puerperal fever were produced in cases in which the most decided evidence of erysipelas alone existed, and therefore the assumption of a special peculiar disease *sui generis* (puerperal fever) was unnecessary; that in the case of primiparæ, lacerations to an appreciable extent being the rule, great facility of ingress and onset, so far as the poison of erysipelas is concerned, is their chief source of liability to attack, which latter appears statistically to be true; that with reference to puerperal pyæmia, it merely forms a feature alike common to all acute specific diseases (most especially, however, of erysipelas), being unaccountable for by the doctrine of phlebitis, of thrombosis, of a pyohæmia, and consisting of a general process of abscess, called into action as a special eliminant, when the ordinary agencies fail to expel a virus, and carried on by a relative process between the tissues (connective) and the blood-current, in which thrombosis is common; and lastly, that much of the mortality is preventable. The propositions were supported by cases.

Dr. TYLER SMITH said the subject of puerperal fever was the most important which could occupy the attention of the Society. The whole obstetric mortality of England and Wales exceeded 3,000 annually. Of this number of deaths more than 1,000 women, or nearly three daily, fell victims to puerperal fever; and it was the healthy and vigorous primipara whom it was most prone to attack. The obstetrist could put before him no nobler object than the diminution of this mortality. Unhappily, we could not look to treatment to accomplish this. Under various circumstances, and in different countries, every variety of treatment had been tried and been found wanting. If not curable, it was however preventable. It was not, therefore, to treatment, but to prevention, that we must look for the means of dealing with it successfully. If epidemics of puerperal fever were less rife now than in former times—and at present they rarely occurred, except from the crowding of women in lying-in hospitals—it was because we lived under better sanitary conditions, and paid more especial attention to preventive measures. We should surround every lying-in woman, as far as possible, with antiseptic precautions. Nothing, he believed, would tend more to diminish the frequency of puerperal fever than the full recognition of its infectious and contagious nature, in whatever way it first occurred. It would not so often happen if all accoucheurs recognized the fact that erysipelas, typhus, scarlatina, small-pox, hospital gangrene, putrid sore-throat, diphtheria, the *post-mortem* and other

poisons were excessively prone, if brought near the lying-in woman, to originate puerperal disease. He did not question but that any of the agents which produced zymotic maladies might cause puerperal fever, or that it might arise in individual cases from the retention and putrefaction of portions of placenta or membrane or coagula, or the decomposition of fibrinous clots in the uterine vessels, especially in women who were predisposed by hemorrhage, albuminuria, or other causes of debility; but contagion and infection, which might to a great extent be recognized and avoided, were its chief and most preventable sources. If all our means, in the way of prevention, were habitually brought into operation, he did not doubt that puerperal fever, instead of being the highest, might become a very moderate cause of obstetric mortality.—*Medical Times and Gazette*, November 23, 1861.

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68. *The Pathogeny of Retro-uterine Hæmatocele.*—Prof. Braun, of Vienna, has reported ten cases of retro-uterine hæmatocele; and the following are some of the conclusions at which he has arrived: 1. In the ten cases, the diagnosis was made with certainty in eight, and with probability in two. Nine of the patients recovered perfectly; in the fatal case, there were extra-uterine pregnancy and obsolete peritonitis. In seven cases, the indications afforded by exploratory puncture were very encouraging. Puncture and entire evacuation of the tumour was followed by cure in six cases; in three, recovery took place under passive treatment. In six cases, the hæmatocele was retro-uterine; in four, antero-uterine. In none of the cases did the extravasation surround the uterus; it was always confined to one-half of the pelvis. 2. Rapid cure may follow the emptying of the hæmatocele by puncture; the fertility of the patient is not destroyed; and a subsequent pregnancy and parturition may follow their normal course. 3. Movable pelvic tumours, which careful palpation and examination show to be probably hæmatoceles, are recovered from under or after inunction of iodine and glycerine. 4. The quantity of blood contained in a uterine hæmatocele may vary from a few drachms to several pounds. 5. The blood extravasated in the neighbourhood of the uterus undergoes a metamorphosis; the corpuscles become broken up, and their membranes appear flabby and eroded; they do not undergo putrefaction, and immediately after evacuation do not bruit a putrid smell. When the hæmatocele is of long standing, dark brown spots are formed on its walls; the blood-corpuscles are absorbed, and a greenish yellow fluid is left, having the specific gravity of the blood-serum, with an alkaline reaction, and containing albumen, a very large amount of albuminate of soda, a little biliverdin, no ammonia, very little sugar, but the salts of the blood-serum, with a preponderance of the chlorides. The fluid removed by the trocar from the hæmatocele generally contains blood of a tarry, ropy consistence, not of bad odour, with numerous patches of pigment, and with hæmatin; it also contains crystals of ammonio-phosphate of magnesia. 6. During the existence of a hæmatocele, menstruation sometimes runs a normal course, without pain; sometimes it is very profuse and painful, and is generally attended by enlargement of the blood-cyst; sometimes hæmatocele exists coincidentally with menorrhagia of several months' duration. Intense anæmia is generally only observed where the hæmatocele is complicated with menorrhagia; without this, its presence is compatible with the retention of a healthy colour of the face. 7. The growth of a hæmatocele is sometimes slow, sometimes very rapid. It may in a few days attain the size of a man's head; and in this case the symptoms are generally those of an internal hemorrhage. 8. Some days after the emptying of a hæmatocele, the exudation acquires a penetrating odour, which may be removed by careful injection of the cyst with warm water. 9. Menorrhagia occurring in conjunction with a hæmatocele soon ceases, as soon as the hæmatocele is perfectly emptied. 10. Prolapsus of the vagina may be produced by hæmatocele, with or without the presence of pregnancy. 11. In the highest grade of antero-uterine hæmatocele, the tumour reaches downwards lower than the orifice of the urethra, and upwards as far as the umbilicus. 12. The bladder and uterus are generally pushed upwards by the tumour, more frequently forwards, rarely backwards and to the side. The direction of the displacement may be ascertained by careful catheterization. A hæmatocele projecting into